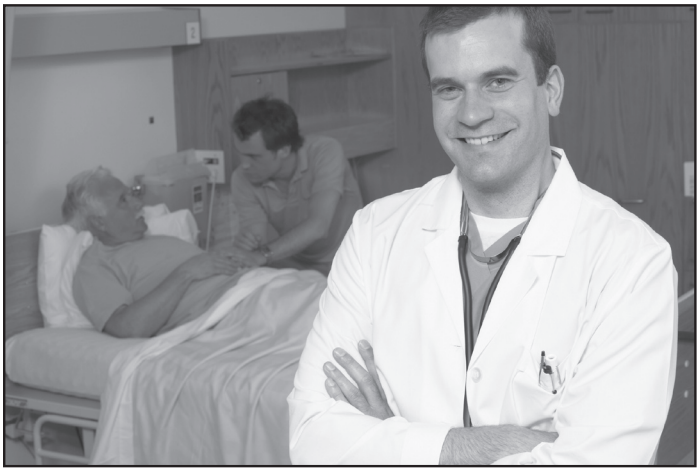
Section D
Medicare Part A hospital insurance



Medicare Part A

Medicare Part A helps pay for services you receive from a:

- **Hospital**
- **Home health agency**
- **Skilled nursing facility**
- **Hospice program**

- Medicare Part A has a **free** premium for those who have accumulated 40 or more Social Security work credits. Generally, this equates to 10 years of work history. One credit is earned for each quarter in which a specific amount of income has been earned. A person who has not worked may draw on the spouse's record. This amount may change.
- American citizens and lawfully admitted aliens who are not eligible for premium-free Part A may get Part A coverage by paying a monthly premium.

The 2009 Part A premium amount for people who buy Part A is up to $443 each month (2009).

Hospital coverage

Hospital inpatient care is covered if a physician prescribes the treatment, the beneficiary requires care that can only be received in a hospital and Medicare approves the stay. NOTE: Medicare does not pre-approve services.

1. Part A benefit period/deductible
   A. Each Medicare Part A benefit period provides 90 days of hospital care, if needed.
      - **For days 1–60, the beneficiary pays a $1,068 deductible (2009)**. Medicare will cover 100 percent of the remaining costs of hospitalization.
      - For days 61–90 in a benefit period, the beneficiary pays $269 coinsurance per day (2009).

      NOTE: Part B charges may also be incurred during hospitalization.

   B. There are no limits on the number of benefit periods a Medicare beneficiary can have in a lifetime.
      - The Part A benefit period is not based on a calendar year. A new benefit period begins each time a beneficiary is out of the hospital and has not received skilled care in any other facility for 60 or more consecutive days.
      - The deductible will apply to each new benefit period.

   C. In addition to the 90-day renewable benefit period, each Medicare beneficiary has **60 nonrenewable, lifetime reserve days**.
      - Lifetime reserve days can only be used when the Medicare beneficiary has exhausted the 90 hospital days allowed within a benefit period.
      - The beneficiary pays $534 per day (2009) coinsurance for each lifetime reserve day.
      - Very few people ever exhaust their 60 lifetime reserve days.
      - Beneficiaries have the option of whether or not to use reserve days. Use of reserve days is assumed unless the beneficiary notifies the facility in writing that they are not using reserve days.

2. **Part A services covered**

A. Semi-private room and board
B. Special care units (i.e. intensive care unit or coronary care unit)
C. General nursing services
D. Drugs administered to you while you are in the hospital
E. Lab tests included in the hospital bill
F. Radiology services included in the hospital bill (i.e., X-rays, radiation therapy)
G. Medical supplies such as casts, splints, and surgical dressings
H. Operating and recovery room costs
I. Rehabilitation services such as physical therapy, occupational therapy, and speech pathology services
J. Use of appliances (i.e., wheelchairs)
K. Blood transfusions after the first three pints

3. **Part A services not covered**

A. Personal convenience items, i.e., television, telephone (if billed separately)
B. **Extra charges for private room unless**
   - **It is medically necessary, or**
   - **It is the only type of room available.**

C. The first three pints of blood (unless the blood deductible has been satisfied under Part B)
D. Private duty nursing

4. **Miscellaneous hospital coverage**

A. **Care in psychiatric hospital**
   - Medicare pays for no more than **190 days of inpatient care in a participating psychiatric hospital in a lifetime.**
   - Jamestown State Hospital and the Stadter Center in Grand Forks are inpatient psychiatric facilities. They provide inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.

NOTES: Lifetime reserve days do not apply to psychiatric hospitalizations. Hospitalizations in the psychiatric wing of a medical hospital are treated as regular medical hospitalizations. Outpatient mental health services are covered under Part B.

B. **Care in foreign hospital**
   - Medicare will help pay for care in qualified Mexican or Canadian hospitals in three limited situations.
     1. The beneficiary is in the United States when an emergency occurs and a Canadian or Mexican hospital is closer than the nearest United States hospital that can provide emergency services.
     2. The beneficiary lives in the United States and the Canadian or Mexican hospital is closer to their home than the nearest United States hospital regardless of emergency cases.
     3. The beneficiary is in Canada traveling without unreasonable delay by the most direct route to or from Alaska and another state and an emergency occurs that requires admission to a Canadian hospital. (**Emergencies that occur while one is vacationing/ touring in Canada are not covered**.)

- If a Medicare beneficiary plans to **travel outside the United States**, he/she should:
    1. **Check current Medicare supplement insurance** to see if it has foreign travel emergency coverage.
    2. **Buy a specialty policy** that will cover them for accidents and illnesses outside the United States.
    3. Contact a travel agency for a **short-term health insurance policy** for foreign travel.

C. **Care in a Christian Science Sanitarium**

- Medicare pays for inpatient care received in a participating Christian Science sanitarium if it is operated or listed by the First Church of Christ, Scientist, in Boston. (There are none in North Dakota.)

Part A skilled nursing facility (SNF) coverage

Medicare covers nursing home care only under very limited circumstances. Medicare defines skilled nursing care as care that can only be performed by or under the supervision of licensed nursing personnel.

1. SNF coverage criteria (all must be met)
    A. A medical professional **certifies** that the beneficiary needs, and actually receives, skilled nursing or skilled rehabilitation services **daily**.
    B. The skilled services must be ones that can **only** be provided in a SNF on an **inpatient basis.**
    C. The beneficiary must have been in a **hospital** at least **three days** in a row (not counting the day of discharge) before being transferred to a participating SNF. NOTE: Days spent in an observation bed do not count toward the three days of hospitalization.
    D. The SNF stay is required for a **condition** that was **treated in the hospital** (still requires a 3-day hospital stay within the last 30 days).
    E. The beneficiary is **admitted to the SNF within 30 days** after leaving the hospital.
    F. The facility is a **Medicare-certified skilled nursing facility**.

2. Level of care/progress
    A. Only **skilled nursing home care qualifies for Medicare coverage**. **Medicare defines skilled care** as care that can only be performed by licensed nursing or rehabilitation professionals (see page 114 of 2009).
        - Skilled nursing services include:
            - Intravenous feedings
            - Sterile irrigation
            - Treatment of extensive decubitus ulcers (bed sores)
            - Replacement of catheters
            - Application of dressings involving prescription medications
            - Other widespread skin disorders
        - Skilled rehabilitation services include:
            - Therapeutic exercises or activities
            - Ongoing assessment of rehabilitation needs
            - Gait evaluation and training
            - Potential maintenance therapy

- A service that is ordinarily considered non-skilled may qualify as a skilled service when the patient's overall medical condition requires that skilled nursing or rehabilitation personnel manage or perform the treatment plan, observe progress, or evaluate the need for changes in treatment.

- Custodial care (assistance with personal needs by unskilled personnel) and skilled care required only once or twice per week do not qualify for coverage.

• The Medicare contractor will also require:

(1) That a patient show significant rehabilitation potential and steady progress; or

(2) That skilled services are necessary to prevent further deterioration or preserve current capabilities when full recovery or medical improvement is not possible.

3. Benefit period: **100 days**

A. For the **1st** through the **20th** day, **Medicare pays 100 percent** of covered costs for a qualified stay in a skilled nursing facility.

B. For the **21st through the 100th day**, the beneficiary is responsible for a coinsurance of **$133.50 per day** (2009).

4. Skilled nursing facility—services covered

A. A semi-private room (two to four beds in a room)

B. All meals including special diets

C. Regular nursing services

D. Rehabilitation services such as physical, occupational and speech therapy

E. Drugs furnished by the facility during the stay

F. Medical supplies such as splints and casts

G. Use of medical appliances such as a wheelchair

H. Blood, after beneficiary pays for first three pints, unless the beneficiary has previously met the blood deductible under Part B

5. Services not covered

A. Physician services (these are covered under Medicare Part B)

B. Personal convenience items such as television, radio or telephone in the room

C. Private duty nurses

D. Any extra charges for a private room, unless it is required for medical reasons

E. The first three pints of blood received unless satisfied under Part B

F. Custodial care

6. Swing beds

A. Certain rural hospitals with fewer than 99 beds may enter into "swing bed" agreements. These agreements allow beds to be used as either acute (hospital) or long-term (i.e., skilled nursing) care beds depending on the patient's needs.

B. This allows rural hospitals to have available skilled nursing beds for beneficiaries who do not have access to skilled nursing facilities.

C. Medicare Part A will reimburse a qualified hospital on a formula basis, as if it were a qualified SNF.

D. The beneficiary may be responsible for the SNF coinsurance.

Part A Home Health Care

Part A covers the cost of the first 100 home health visits following a hospital stay. Home health care is the delivery of skilled medical attention to homebound patients.

Post-institutional home health services are services furnished to a Medicare beneficiary:
• After an inpatient hospital stay of at least three consecutive days, initiated within 14 days after discharge; or
• After a stay in a SNF initiated within 14 days after discharge.

NOTE: **Home health spell of illness** is the period beginning when a patient first receives post-institutional home health services and ending when the beneficiary has not received inpatient hospital, SNF or home health services for 60 days.

1. **Part A home health care criteria**
   A. The home health agency must be a **Medicare participating agency**.
   B. The **patient** must be an **eligible Medicare beneficiary who is under a doctor's care**. The doctor must prescribe and authorize the services which are reasonable and necessary to the treatment of the patient's illness or injury.
   C. The **patient** must be **confined to his/her home**.

To be considered homebound, both criteria 1 and 2 must be met.

Criteria 1—The patient's medical condition restricts his ability to leave the home:
• Without the assistance of another individual; or
• Without the assistance of a supportive device; or
• Because absences from the home are medically contraindicated.

Criteria 2—The patient leaves the home:
• Only to receive medical treatment which cannot be provided in the patient's home; or
• Infrequently and for short periods of time for nonmedical purposes and these absences do not indicate the patient has the capacity to obtain health care provided outside rather than inside the home.

NOTE: A beneficiary may leave home to attend a licensed or certified adult day care without affecting their homebound status. The beneficiary may attend religious services.

2. **Home health care benefit**

• Upon referral by a physician, the home health agency will provide a free evaluation to determine if the beneficiary qualifies for coverage.
• Medicare pays 100 percent of covered and medically necessary services. There is no deductible.
• Claims for payment are submitted by the home health agency and payment is made directly to the agency. The beneficiary receives a "Medicare Summary Notice" showing what was billed; Medicare's portion of the bill; and what, if any, charges the individual must pay.

3. **Home health covered services**
   A. Part-time or intermittent skilled nursing care
   B. Therapy (physical, speech and occupational)
   C. Medical social services (i.e., dietary counseling)
   D. Part-time or intermittent care (e.g., bathing and changing of dressings)
   E. Medical supplies when billed by the home health agency
   F. Durable medical equipment (subject to 20 percent coinsurance)

4. **Home health aide services** (may be covered if received in conjunction with skilled care services)
   A. To furnish personal care
   B. To maintain a beneficiary's health
   C. To facilitate treatments

5. **Home health services not covered**
   A. Drugs
   B. Homemaker/general household services
   C. "Meals on Wheels" or personal services

Part A Medicare hospice care

Hospice is a public agency or private organization whose primary role is to provide pain relief and symptom management to terminally ill patients.

1. **Hospice care criteria**
   A. **Doctor certifies** the patient is **terminally ill** (diagnosed as having six months or less to live if the illness runs its normal course).
   B. Patient elects to **receive care from hospice instead of regular Medicare** benefits for the terminal illness.
   C. **Care** is provided in a **home, hospital or nursing home** by a Medicare certified hospice.
   D. Hospice care in a nursing home is limited to **pain relief care only**. Medicare does cover room and board.
   E. Respite care

2. **Hospice benefit period**
   A. Medicare will pay for up to two 90-day periods followed by an unlimited number of 60-day periods.
   B. The Medicare hospice benefit only pays for treatment for pain relief and symptom management of a terminal illness.
      • Original Medicare will usually help pay for treatment not related to the terminal illness. Deductibles and coinsurance will apply.
   C. Medicare pays 100 percent of most covered hospice services. There is no deductible or coinsurance.

D. The beneficiary will have to pay small coinsurance fees for outpatient drugs and inpatient respite care.

3. **Hospice services covered**
   A. Doctor and nursing services
   B. Home health aid and homemaker services
   C. Medical supplies and appliances
   D. Physical, occupational and speech therapy
   E. Drugs (including outpatient drugs for the purpose of pain relief).
      • The beneficiary is responsible for five percent of the cost of outpatient drugs or $5 toward each prescription, whichever is less.
   F. Counseling
   G. Medical social services
   H. Short-term inpatient care (including respite care)
      • The beneficiary pays a minimal per day portion of the Medicare-allowed rate for inpatient respite care.
      • Inpatient respite care is limited to no more than five days in a row.

Section D
Review exercise

1. Name four areas of Part A coverage.

   a.
   b.
   c.
   d.

2. For a person who signs up at age 65 for Medicare and is eligible for Social Security, what is the current Part A premium?

3. What is the current Medicare Part A deductible?

4. Mr. Smith enters the hospital on January 2 and stays for 20 days. He is discharged to his home and after 35 days must return to the hospital for an additional 10 days. What are his out-of-pocket costs on the hospital bill?

5. There are 60 non-renewable lifetime reserve days for Medicare Part A. This is a feature that is rarely utilized. T _____ F _____

6. Which of the following services is not covered under Medicare Part A?
   a. Operating room costs
   b. Intensive care
   c. Drugs administered to you while in this hospital
   d. Surgeon charges

7. Under what two circumstances will Medicare pay for a private hospital room?

a.

b.

8. What is the lifetime maximum benefit for Medicare coverage in a certified inpatient psychiatric hospital?

9. While traveling as a tourist in Canada, Medicare will not pay for any Part A expenses. T _____ F _____

10. If you wish to travel overseas, what should you do about health insurance?

11. What conditions must be met before Medicare will pay for skilled nursing facility care?

a. d.
b. e.
c. f.

12. Medicare pays for all levels of care in a nursing home. T _____ F _____

13. How many days can Medicare cover during each benefit period in an SNF?

14. What does Medicare pay for the 21st–100th day in an SNF if the stay is approved?

15. What is the criteria for Medicare Home Health coverage?

a.
b.
c.

16. CASE SCENARIO: Mr. Williams is a slightly confused 88 year old man who needs a nurse to draw a monthly Digoxin level. He uses the assistance of a walker to ambulate. A neighbor comes by each evening to drive Mr. Williams to a local café. The skilled nurse feels this may be the only meal Mr. Williams has each day.

Is Mr. Williams considered homebound? Yes _____ No _____

17. What are Medicare's requirements for coverage of hospice care?

a.
b.
c.
d.

18. Doctor and nursing services, homemaker services, and short-term respite care services are covered by:

a. Home health care coverage
b. Hospice coverage
c. Skilled nursing facility